

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2700
Registrar's No. 832

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place) 13 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,		d. STREET ADDRESS (If rural, give location) 3310a Magnolia Avenue	

3. NAME OF DECEASED (Type or Print) ARTHUR	a. (First) H	b. (Middle)	c. (Last) GERDES	4. DATE OF DEATH (Month) JAN. (Day) 27 (Year) 1949
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH March 4, 1886	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Hours 23
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME August Gerdes	13b. MOTHER'S MAIDEN NAME Anna Ranken	14. NAME OF HUSBAND OR WIFE Henrietta Estel
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Kenneth Gerdes, 4401 Alaska Avenue	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute bacterial endocarditis due to Staph. aureus		4
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis - now calcareous			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan. 14, 1949, to Jan. 27, 1949, that I last saw the deceased alive on Jan. 27, 1949, and that death occurred at 12:45A m.; from the causes and on the date stated above.

23a. SIGNATURE F. R. Bradley (Degree or title) M.D.	23b. ADDRESS Barnes Hospital,	23c. DATE SIGNED 1/27/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/29/49	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. JAN 28 1949	REGISTRAR'S SIGNATURE J. B. Lester	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Neal G Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St. Louis Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.